ALCOHOL AND OTHER DRUG PROBLEMS AMONG ADDICTION PROFESSIONALS

PROCEEDINGS FROM THE 2006-2007 SYMPOSIUM SERIES

Southeast Addiction Technology Transfer Center

Kay Gresham, Director

SOUTHEAST attc

ALCOHOL AND OTHER DRUG PROBLEMS AMONG ADDICTION PROFESSIONALS

PROCEEDINGS FROM THE 2006-2007 SYMPOSIUM SERIES

Southeast Addiction Technology Transfer Center

Kay Gresham, Director

Facilitated by Terence T. Gorski, MA, MAC, NCAC II, CSAC

Proceedings Written by Pamela Woll, MA, CADP, Consultant

Alcohol and Other Drug Problems Among Addiction Professionals

Proceedings from the 2006-2007 Symposium Series

Published in 2007 by Southeast Addiction Technology Transfer Center (ATTC), National Center for Primary Care at Morehouse School of Medicine, 720 Westview Drive SW, Atlanta, Georgia 30310. This proceedings document was developed by Pamela Woll, MA, a consultant to Southeast Addiction Technology Transfer Center, based on the discussions that took place at a series of two Symposia sponsored by Southeast ATTC and facilitated by Terence T. Gorski, held September 7-8, 2006 in Greenville, South Carolina and March 22-23, 2007 in Savannah, Georgia.

This publication was prepared under a cooperative agreement from the Department of Health and Human Services (DHHS), Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT).

At the time of this publication, Terry Cline, PhD served as SAMHSA Administrator. H. Westley Clark, MD, JD, MPH served as CSAT Director; and Catherine D. Nugent, MS served as CSAT Project Officer. The opinions expressed herein are the views of the authors and do not necessarily reflect the official position of DHHS, SAMHSA, or CSAT. No official support or endorsement of DHHS, SAMHSA, or CSAT for the opinions described in this document is intended or should be inferred.

Produced under a Cooperative Agreement from the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment.
Center for Substance Abuse Treatment, 1 Choke Cherry Road
Rockville, MD 20857, 301.443.5700
Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the agency.
Grant No. TI13589-05

TABLE OF CONTENTS

ACKNOWLEDGMENTS

Funding and Conference Sponsorship

Southeast Addiction Technology Transfer Center (Southeast ATTC), wishes first and foremost to thank our funding source, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment (SAMHSA, CSAT), without whose support none of our work would be possible. Special thanks to SAMHSA Administrator Terry Cline, PhD and CSAT Director H. Westley Clark, MD, JD, MPH, CAS, FASAM for their ongoing commitment and support.

In addition, we wish to acknowledge the vision, guidance, and support of our National ATTC Network, whose work truly does unify science, education, and service to transform lives. Special thanks to Catherine D. Nugent, MS, CSAT Project Officer for the ATTC Network. We also wish to thank our sponsoring educational institution, the Morehouse School of Medicine (MSM), National Center for Primary Care (NCPC), with particular thanks to our President, John Maupin, DDS, MBA and our Principal Investigator, George S. Rust, MD, MPH.

We extend our gratitude to our facilitator, Terence T. Gorski, MA, MAC, NCAC II, CSAC, founder and President of the CENAPS Corporation, whose wealth of knowledge and experience informed and crafted a symposium structure that forged deep bonds among the participants and brought out their best knowledge and wisdom on the subject.

We have nothing but gratitude and admiration for our symposium participants, whose love and dedication fueled discussions that were harmonious even in their diversity of opinion:

Henry Braddock, PhD, Braddock & Associates, Atlanta, Georgia

Charles E. Cofer Jr., CACIIit, RPP, PD, Palm House, Athens, Georgia

Velda De Young, CACI, Spartanburg Alcohol and Drug Abuse Commission, Spartanburg, South Carolina

T.J. Elison, BA HRA, SHRM-NSC DDI, Atlanta Union Mission, Atlanta, Georgia

Arnold Evans, CACII, Licensed OPT, The Alternative, Lexington, South Carolina

Catherine Gayle, PhD, MSW, LCSW, CCFC, Min., West Georgia Technical College, Lagrange, Georgia

Quinten G. Gresham, Jr., LCSW, ACSW, Families First, Atlanta, Georgia

Genice Hall-Summers, LISW-CP, ACSW, CPP, CACII(P), CACII(P), FairField Behavioral Health Services, Winnsboro, South Carolina

Louise Haynes, MSW, Medical University of South Carolina (MUSC), Charleston, South Carolina

Demetrius Henderson, MEd, MBA, LPC, South Carolina Department of Mental Health, Columbia, South Carolina

Barbara Holmes-Hampton, MSW, MAC, CPT, Hampton & Associates, Atlanta, Georgia

Gloria D. Jones, PhD, NCACII, CCS, Heritage Foundation, Inc., Thomasville, Georgia

Karen Kelly, PHD, LPC, MAC, CCS, ACRPS, CCJS, Circle of Recovery, Inc., Decatur, Georgia

Janet Lenard, EdD, LCSW, MSSW, Southeast Regional Medical Center Army Substance Abuse Program, Fort Gordon, Georgia

Arthur Logan, MA, NCAC II, Clemson University, Clemson, South Carolina

Cherly Azouri Long, CSPP, ICSPP, NCACII, CACII, CTC, PRI/DUI, Axis 1 Center of Barnwell, Barnwell, South Carolina

Taunya A. Lowe, MA, Consultant/Trainer, Lawrenceville, Georgia

Bryant Miller, MRE, CACII, CCS, MAC, Penfield Christian Home, Inc., Union Point, Georgia

Bonnie Pate, BS, South Carolina SHARE, West Columbia, South Carolina

Lee Robinson, CACII, JD, Steppingstones to Recovery, Augusta, Georgia

Onaje Salim, LPC, MA, MAC, CCS, Georgia Department of Human Resources, Atlanta, Georgia

Dan Sharpe, MA, Behavioral Health Services of Pickens County, Pickens, South Carolina

Christopher Sheffield, BA, CACII, Heritage Foundations, Inc., Thomasville, Georgia

Jim Van Hecke, BA, Addiction Recovery Institute, Tryon, NC

Vonshurii S. Wrighten, MDiv, MAC, CACII, CCS, Morehouse School of Medicine, Southeast ATTC, Atlanta, Georgia

We wish also to acknowledge others in the field who have addressed this difficult and controversial subject, in particular William L. White, MA, who made his new article "Alcohol, Tobacco and Other Drug Use by Addictions Professionals: Historical Reflections and Suggested Guidelines" (published by the Great Lakes ATTC in September, 2006) available to the planners of and participants in this symposium.

Last but by no means least, we wish to acknowledge the many addiction professionals who work so hard and care so much, under conditions that require all the skill they can gain and all the hope they can generate. Those who have fallen to addictive disorders of their own, we thank for their service and the lessons they have taught us. Those who have risen above these disorders, we thank for their inspiration and their clear message-that recovery lives and passes from soul to soul.

EXECUTIVE SUMMARY

Some issues draw attention because of their broad scope, and others because of their depth and potential impact. In September, 2006 and March, 2007, thirty leaders in the addiction field gathered in Greenville, South Carolina and Savannah, Georgia to grapple with an issue whose scope is still unknown and whose consequences, when they arise, can be devastating.

"Alcohol and Other Drug Problems Among Addiction Professionals" was the title of the Symposium Series sponsored by Southeast Addiction Technology Transfer Center and facilitated by Terence T. Gorski. The participants, leaders from the states of Georgia and South Carolina, found in one another rich resources of passion, dedication, knowledge, experience, humor, and hope. In the topic they found a door to the very core of the field's work: Effective, ethical, fair, and humane treatment of human beings.

The tendency of compassion to grow out of pain has led many people from troubled backgrounds to seek work in the helping professions. The addiction field's historical roots in recovery have given it higher concentrations of recovering staff than most other helping fields. Escalating needs and dwindling resources have raised the field's levels of stress and fatigue and made it more and more difficult to find the time and the will for self-care. And society's relentless stigmatization of people with addiction has often distorted the field's awareness of, and response to, the alcohol and other drug (AOD) problems that arise among its staff.

When these problems are denied or mishandled, they can endanger or destroy the fragile recovery and well being of vulnerable clients; the careers and potential of dedicated but struggling employees; the harmony and equilibrium of service teams and entire organizational cultures; and community perception of, and belief in, the treatment organization, the treatment field, and recovery itself.

When these problems are addressed in humane, effective, and situation-appropriate ways, they can save lives, restore careers, preserve the effectiveness and integrity of the treatment organization, and make a powerful statement about the strength and resiliency of recovery. At the first symposium, participants identified twelve core needs that the field and its leaders must consider to craft effective responses to these issues. They are as follows:

Elements Needed to Inform This Process

1. **Research Data:** We need research data on the prevalence, extent, and effects of impairment within the addiction profession. This includes an operational definition of impairment that is broad based and not restricted to AOD use.
2. **Needs Assessment:** We need to complete comprehensive needs assessments to determine current practices; evaluate their effectiveness; and identify factors related to successful professional practice, and those related to practices that lead to impaired performance. We need to determine the needs that must be met in order for addiction professionals to function at optimal levels of performance.

Overarching Considerations

3. **Standards:** We need to establish national, regional, and local standards on impairment and Employee Assistance Program (EAP) practices for the addiction profession, and produce an authoritative resource guide. We need to join forces with other agencies and professional groups to accomplish this goal.
4. **Fair Labor Laws:** We need to ensure fair practices compliant with fair labor laws in all states. We need to unify fair labor practices under national and international standards.
5. **Privacy:** We need to define ways of balancing personal privacy with professional duties, responsibilities, and obligations.
6. **Non-Discriminatory Policies and Practices:** Organizations should develop non-discriminatory policies and procedures that prevent and manage problems that addiction professionals might experience. These policies and procedures include: (1) consistent codes of ethics and (2) consistent hiring practices.

Areas of Policy and Protocol

7. **Hiring Policies:** (1) These must be consistent with current federal, state, and local laws and agency vision, mission, policy, and procedures. (2) They should value life experience, professional experience, and academic credentials.
8. **Competency-based Evaluations:** There should be a competency-based evaluation of core addiction treatment competencies. TAP 21 can be used as a guide. Organizations need to develop Bona Fide Occupational Qualifications (BFOQ) for each job category and provide proper orientation of all employees to all job-related expectations, vision, mission, policies, and procedures.
9. **Supervision Best Practices:** We need to develop written guidelines for Best Practices to guide supervision and professional practices.
10. **Training and Mentoring:** Organizations should provide training programs for staff, including administration, managers, supervisors, and line staff, with a strong focus upon orienting new employees so they can rapidly become effec-

tive in their jobs. These processes should become standardized on the agency level consistent with federal, state, and local laws and agency policies. Organizations should provide on-the-job training and mentoring programs to help people acquire the competencies necessary to do their jobs. Training is an ongoing necessity because of the rapid change in environment and the need to address both "uncomplicated" addiction and addiction complicated by coexisting mental health disorders, legal problems, and social problems.

11. **Wellness:** Organizations should develop wellness programs and practices to take care of employees, and provide effective supervision policies and practices that consider the wellness of the employees. These should include specific scheduled activities, including such things as retreats for the purpose of rejuvenation and burn-out prevention, peer support and mentoring practices, and "growth groups" to enhance professional development. These groups would be aimed at self-awareness and "spirituality recharge."

12. **Impairment Policies:** We need practical and enforceable policies for addressing impaired professionals that reflect fair practices consistently applied to all addiction professionals and support staff. These policies should build trust and consistency in their application to staff at all levels of the organization. They should include wellness policies designed to prevent problems and remain consistent with professional and agency codes of ethics. They need to: (1) be enforceable, (2) be fair, (3) engender trust, (4) promote wellness, and (5) support high ethical standards. This includes the training of boards of directors, clinical management teams, physicians, and therapeutic and support staff.

Participants met again six months later to discuss what they had learned and the tools they had begun to create to help fulfill these needs. This Proceedings document is an invitation to join, inform, explore, and expand this discussion. The debate and the crafting of solutions will have to continue on a far wider scale, at organizational, regional, national, and international levels. The magnitude of each addiction professional's potential to heal or to harm deserves no less.

CHAPTER 1: INTRODUCTION

CHAPTER 1: INTRODUCTION

The Symposium Series

The September, 2006 and March, 2007 symposia were held in response to a number of concerns voiced by leaders in the chemical dependency field. From the stigmatization of recovering professionals to the danger of repercussions when professionals relapse, the issues that arise in this area are complex and difficult to address, but essential to the ethical health of the field.

"Alcohol and Other Drug Problems among Addiction Professionals" was sponsored by Southeast Addiction Technology Transfer Center (Southeast ATTC), one of 14 Regional Centers in the Addiction Technology Transfer Center Network. Funded by the Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment (SAMHSA, CSAT), Southeast ATTC:

- Fosters alliances and collaborative efforts to support and implement the most effective evidence-based practices in the treatment of substance use disorders
- Provides training, technical assistance, and other technology transfer activities to increase the awareness, knowledge, and skills of practitioners and pre-service professionals
- Develops and disseminates written resources to assist the treatment field and allied health and human service fields in their pursuit of greater effectiveness

The ATTC Network is dedicated to identifying and advancing opportunities for improving addiction treatment. Its vision is to unify science, education, and services to transform the lives of individuals and families affected by alcohol and other drug addiction. Along with their SAMHSA/CSAT funding, the Addiction Technology Transfer Centers also receive support from the National Institutes of Health, National Institute on Drug Abuse (NIH, NIDA) to bring the benefits of NIDA research to the treatment community.

The two symposia were facilitated by Terence T. Gorski, long known as a leader and authority in the addiction, behavioral health, social services, and corrections fields for his work in recovery and relapse prevention. Mr. Gorski is founder and President of The CENAPS Corporation, a training and consultation firm that provides solutions to the problem of relapse through advanced training in clinical systems and workforce development.

Participants in the two symposia brought a wealth and depth of knowledge and experience to the discussion. Participants included:

Henry Braddock, PhD, Braddock & Associates, Atlanta, Georgia

Charles E. Cofer Jr., CACIIit, RPP, PD, Palm House, Athens, Georgia

Velda De Young, CACI, Spartanburg Alcohol and Drug Abuse Commission, Spartanburg, South Carolina

T.J. Elison, BA HRA, SHRM-NSC DDI, Atlanta Union Mission, Atlanta, Georgia

Arnold Evans, CACII, Licensed OPT, The Alternative, Lexington, South Carolina

Catherine Gayle, PhD, MSW, LCSW, CCFC, Min., West Georgia Technical College, Lagrange, Georgia

Quinten G. Gresham, Jr., LCSW, ACSW, Families First, Atlanta, Georgia

Genice Hall-Summers, LISW-CP, ACSW, CPP, CACII(P), CACII(P), FairField Behavioral Health Services, Winnsboro, South Carolina

Louise Haynes, MSW, Medical University of South Carolina (MUSC), Charleston, South Carolina

Demetrius Henderson, MEd, MBA, LPC, South Carolina Department of Mental Health, Columbia, South Carolina

Barbara Holmes-Hampton, MSW, MAC, CPT, Hampton & Associates, Atlanta, Georgia

Gloria D. Jones, PhD, NCACII, CCS, Heritage Foundation, Inc., Thomasville, Georgia

Karen Kelly, PHD, LPC, MAC, CCS, ACRPS, CCJS, Circle of Recovery, Inc., Decatur, Georgia

Janet Lenard, EdD, LCSW, MSSW, Southeast Regional Medical Center Army Substance Abuse Program, Fort Gordon, Georgia

Arthur Logan, MA, NCAC II, Clemson University, Clemson, South Carolina

Cherly Azouri Long, CSPP, ICSPP, NCACII, CACII, CTC, PRI/DUI, Axis 1 Center of Barnwell, Barnwell, South Carolina

Taunya A. Lowe, MA, Consultant/Trainer, Lawrenceville, Georgia

Bryant Miller, MRE, CACII, CCS, MAC, Penfield Christian Home, Inc., Union Point, Georgia

Bonnie Pate, BS, South Carolina SHARE, West Columbia, South Carolina

Lee Robinson, CACII, JD, Steppingstones to Recovery, Augusta, Georgia

Onaje Salim, LPC, MA, MAC, CCS, Georgia Department of Human Resources, Atlanta, Georgia

Dan Sharpe, MA, Behavioral Health Services of Pickens County, Pickens, South Carolina

Christopher Sheffield, BA, CACII, Heritage Foundations, Inc., Thomasville, Georgia

Jim Van Hecke, BA, Addiction Recovery Institute, Tryon, NC

Vonshurii S. Wrighten, MDiv, MAC, CACII, CCS, Morehouse School of Medicine, Southeast ATTC, Atlanta, Georgia

Although the majority of participants attended both symposia, some were able to attend only the first or second symposium.

This proceedings document was written by Pamela Woll, MA, CADP, a consultant to Southeast ATTC, based on the discussions that took place during the two events.

Goals of the Symposium Series

Based on the initial thoughts and concerns voiced by Southeast ATTC and its constituents during the planning phase, Terence T. Gorski crafted a framework of discussion questions and exercises that engaged participants' thoughts, emotions, convictions, and vision toward their common purpose.

The first goal of the Symposium Series was to explore and articulate the extent of problems caused by the use of alcohol and other drugs among working addiction professionals, with a special focus on:

- The relapse of previously recovering professionals to alcohol and other drug use
- The development of alcohol and other drug problems among addiction professionals who have not had a history of substance use problems
- Boundaries between appropriate and inappropriate use of medically prescribed mood-altering medications such as antidepressants, anti-anxiety agents, pain killers, and sleeping medications by addiction professionals working in the field

The ultimate goals of this series were to:

- Propose solutions to these challenges
- Begin the process of experimenting with these and other potential solutions
- Inspire further dialogue on the subject within the field

This process has taken place within the context of a national movement toward Recovery-Oriented Systems of Care, supported by the efforts of the Substance Abuse and Mental Health Services Administration. Both the high stakes involved in substance-use problems among treatment professionals and the high level of national interest in recovery may provide momentum toward ongoing attention to this vital topic.

Recurring Themes

While the discussions varied widely in their scope and detail, a number of issues arose repeatedly during the Symposium Series. These included:

- LACK OF DATA: Early in the first symposium, one participant warned of the danger of navigating the "data-free zone" that so many of these issues seem to occupy. This is a natural outgrowth of the lack of attention that this subject has so often drawn. The lack of empirical data on the incidence, prevalence, and consequences of these problems sparked many more calls for more information that will take this discussion out of data-free zone.
- LACK OF CONSISTENT DEFINITION OF TERMS: One price of working in an area of great complexity and diversity is the difficulty of arriving at uniform definitions of terms as basic as "recovery" and "relapse." The many shades of meaning attached to these and other words require that the field arrive at a commonality of terms before it can find common solutions.
- LACK OF KNOWLEDGE OF LAWS AND STANDARDS: On many occasions during the discussions, participants identified areas of policy in which they needed more information. These leaders determined that the gaps in their own knowledge of applicable laws and standards might reflect similar gaps in the field as a whole, including its leadership.
- LACK OF OPPORTUNITIES FOR DISCUSSION: Participants in general agreed that the topics addressed in the Symposium Series seldom come up for discussion in the field.
- INTENSITY AND DIVERSITY OF OPINION: Although the sense of camaraderie among participants never failed, and continued to grow stronger through the two symposia, many of the discussions sparked strong and passionate viewpoints across a wide spectrum of opinion.
- LACK OF CONSISTENT POLICIES: In many of these issue areas, participants identified inconsistencies among policies within individual organizations, and among policies adopted by organizations with similar characteristics. These inconsistencies add a layer of complexity to this inquiry. This is in many ways a legacy of the field's "grassroots" past, a legacy that has fostered passion and commitment but has made the process of maturation and organization more difficult.
- LACK OF ADHERENCE TO EXISTING POLICIES: Many participants pointed out issue areas in which organizational policies are not followed, or are followed inconsistently. There may be one set of written or unwritten standards for people in recovery and another for people who have not self-identified as having had a problem with alcohol or other drugs. And in some cases standards may be applied more leniently to employees who are valued more highly by the organization.

- NEED FOR CONSISTENT STANDARDS: Consequently, a common theme was the need to explore, establish, communicate, and apply consistent standards within an organization, and within the field.
- FOCUS ON PERFORMANCE: In the group's many discussions of policies toward employees, another recurring theme was the importance of focusing first on employees' performance and letting the other issues fall into place around that focus.
- NEED TO HOLD COUNSELING STAFF TO HIGH STANDARDS: One concern that rose above concerns for the well being of counseling staff was the need to hold staff to standards that would protect client well being and foster the most effective services possible.

These themes were woven throughout the discussions described in the following chapters.

Central Challenges in This Discussion

At the end of the second symposium, participants discussed the symposium process and illuminated a few challenges specific to the field's readiness and ability to address and resolve the issues discussed in this document. They agreed that these challenges must be addressed in the structuring and execution of any future discussions on this topic:

- ADDRESSING COMPLEX AND MULTIFACETED TOPICS IN SHORT PERIODS OF TIME: In a field as overworked as the addiction treatment field, leaders are often forced to try to accomplish too much in the forums that are available to them. For a complex topic such as this, an ongoing process-involving multiple groups of people in multiple venues-will be necessary to find and employ effective solutions.
- ADDRESSING THE DIFFICULT ISSUES: The addiction treatment field is so overwhelmed with difficulty-in the disorders treated, in clients' lives and circumstances, in the communities served, in the funding streams that try to sustain this work-that it is tempting to postpone, avoid, or downplay any difficult issues that do not seem pressing or central to the everyday tasks and burdens. However, when these issues have the potential to threaten the quality and safety of client care, addressing them in all their depth and complexity becomes an ethical duty.
- MAINTAINING A FOCUS ON PEOPLE: It is clear that some of the most pivotal changes must take place at organizational and systemic levels, so administrators and human resources/ organizational development staff are essential contributors to these discussions. However, this raises the risk that conversations will gravitate toward organizational concerns-including legal issues-and away from the human-centered focus on the needs and concerns of individuals within

these organizations. Both in the recruitment of participants in these discussions and in the development of discussion questions and forums, it will be necessary to take special measures to ensure that the focus on the individual-client or staff member-is not lost.

- DEVELOPING CONSENSUS: With a subject that holds as much controversy as this one does, skills in developing consensus are essential to progress in finding solutions. However, the addiction treatment field-and perhaps the entire species-has particular difficulty reaching consensus, or even knowing what consensus is or what is required to approach it. All too often, group processes are dominated by the most assertive members, with other members hiding their reservations under a shield of compliance. Given the collaborative nature of much of the field's work, people often believe they are working on consensus when they are instead either defending their views and positions, giving in to others' arguments to keep from making waves, or trying to find compromise between opposing views. Compromise is a trade-off, in which viewpoints are bartered and sacrificed to reach an arrangement that seems fair. In compromise, each participant's views are diminished in service of maintaining harmony. Everyone loses something. Consensus, on the other hand, is the result of an exchange that uses all opposing viewpoints to forge something new. The ideas and conclusions that emerge from this process transcend the individual views that were combined in their development. Nothing has been lost; all has been transformed. Everyone wins. To promote consensus, group processes will have to begin with ample attention to the process of discussion itself and time for preparation in consensus building.

Contents of the Proceedings Document

The remainder of this document presents the issues and ideas that arose:

Chapter 2: Identifying the Challenges

The Scope of the Problem
Should Recovering Staff be Treated Differently?

Chapter 3: Addressing the Challenges

Leadership
Policy Options
Employer Expectations
Interviewing and Hiring Practices
Privacy and Non-Discrimination
Supervision and Corrective Processes
Support for Policies
Employee Wellness

The appendices provide additional information:

Appendix A: The Twelve Core Needs and Proposed Projects

This appendix re-states the Core Needs (presented in the Executive Summary) and lists the project ideas that participants thought of as ways of fulfilling some of these needs.

Appendix B: Sample Policy: Personal Code of Ethics

This sample policy, ready for customization, was provided by Facilitator Terence T. Gorski.

Appendix C: Funding, Sponsorship, and Facilitation of this Event

This appendix contains more information about the funding source, Southeast ATTC, and the facilitator.

CHAPTER 2: IDENTIFYING THE CHALLENGES

CHAPTER 2: IDENTIFYING THE CHALLENGES

THE SCOPE OF THE PROBLEM

Participants' first challenge was to find out how urgent and how critical these issues are by exploring and defining the scope of alcohol and other drug (AOD) issues among treatment professionals. Their first charge was to discuss the extent of the problem in each of the following areas:

1. The relapse of recovering professionals to AOD use.
2. The development of AOD problems among addiction professionals who have not had a history of previous substance-related problems.
3. The use, misuse, and abuse of, and dependence on, medically prescribed mood-altering medications by professionals working in the field.

Discussions of scope took place within the context of participants' knowledge of the depth of these problems. As more than one participant said, "Even one relapse can be devastating." The problems experienced by one staff member tend to reverberate throughout the team, throughout the organization, and in the lives of vulnerable clients.

Whether or not an employee has a history of alcohol or other drug (AOD) problems-and whether or not the employee's dysfunctional patterns progress to alcohol or other drug use-any impairment in judgment or behavior can threaten the safety and progress of clients whose very lives may depend on their safety and progress in treatment.

In addition, treatment agencies exist within communities, and the treatment field exists within a larger society. The effects of problem AOD use extend far beyond the individual clinician, client, and treatment organization. Addiction treatment agencies, and the field as a whole, have a responsibility for the care and safety of the communities in which they exist. Even a highly supportive community can find its trust and support shattered if an addiction professional violates that trust. This is frequently complicated by the stigma that society attaches to addictive disorders. This stigma has established in some communities a climate of suspicion, mistrust, and judgmentalism. Trust is often more easily broken when it was given with deep reservations.

Issues That Might Arise Include:

- Illegal drug use away from work
- Illegal drug use on the job
- Illegal drug possession
- Arrest for possession, sale, or use of illegal substances
- Arrest and/or conviction for driving under the influence of alcohol or other drugs (DUI)
- Criminal activity on or off the job
- Involvement as perpetrator or victim of domestic violence that is noticeable in workplace, or has come to public attention in the community
- Problems in interpersonal relationships with staff and/or supervisors
- Irresponsible management of personal addiction, mental health, and/or physical health problems that might impair job performance
- Violation of stated standards for professional conduct on or off the job (as representatives of the treatment organization)

Relapse of Recovering Professionals

In their discussion of the relapse of recovering AOD professionals to alcohol or other drug use, participants took their first voyage into the "data-free zone." They did not know the extent of the problem, and it was not for lack of concern or study of the subject. The data simply do not exist. Participants identified several reasons for the lack of qualitative and quantitative information:

- By and large, the research community has neglected this area of study, and the addiction treatment field has failed to press for its inclusion in the research agenda.
- The relative lack of formal discussion and study of this subject in the field has left the matter open to speculation and-more often-neglect. Participants' knowledge is based largely on the scope of their individual knowledge, combined with the anecdotal evidence they have been exposed to during their years in the field.
- The incidence of these problems probably varies widely among agencies, and possibly among regions.

- One group noted a great deal of secrecy about issues of personal behavior among employees who have progressed into relapse patterns, contributing to the hidden nature of these patterns. Sometimes an air of secrecy is one of the first signs of relapse.
- On an organizational level, the reporting of such incidents and their consequences also varies widely. The percentage of incidents resulting in disciplinary measures varies widely from organization to organization, depending on company policies. Even where the reporting of these incidents is mandated, reporting is often inconsistent.
- In many cases, the term "relapse" lacks a consistent definition, with some defining it to include any recurrence of AOD use and others reserving the word for return to problem use. This term can also be restricted to include only the return to AOD use per se, or be expanded to include the progression of dysfunctional thought, feeling, urge, and behavior patterns that may or may not lead to return to use, sometimes known as "dry drunk" syndrome.
- Though they could not cite prevalence figures, some participants at the symposium reported that they had seen many professionals with significant recovery time descend into relapse patterns.

It is not only the chronic and relapsing nature of the brain disease of addiction that contributes to the danger of recurrence among recovering professionals in the field. It is also the over-stressed, under-funded, and under-resourced nature of the addiction treatment field as it has evolved.

The primary impact of managed care has been a climate in which "doing more and more with less and less" is the consistent expectation. The stigma and resulting criminalization of addiction have diverted possible resources away from people with substance use disorders. Meanwhile, the depth and complexity of clients' needs, circumstances, and co-occurring disorders have increased exponentially. The addiction professional is suspended between a vast and growing need and a steadily dwindling resource base.

Most people with the courage to remain in this difficult position will undergo some pressure to sacrifice their own well being for the greater good. Participants noted that many professionals in the field lack self-care and balance in their lives, often leading to compassion fatigue and burnout. The organizations themselves seldom have structured programs or policies that encourage and support self-care. These factors both raise the level of turnover in the field and lead to progressive levels of dysfunction in many of those who remain.

Many sources of support that would mitigate these problems are also lacking. According to participants, many organizations lack formal employee assistance programs (EAPs), and in cases where employees do not trust management, they may be reluctant to use existing EAPs for fear of repercussions.

Participants cited a critical need for:

- Leadership that can instill trust and create a compassionate environment
- Resources for the attraction and retention of healthy, professional staff members
- High-quality clinical supervision to address potential problems, and the means to fund it
- Protection of employee confidentiality in the event that employees do seek help
- Attention to organizational missions and codes of ethics in addressing these issues

Development of New AOD Problems in Staff

Once again, participants found themselves in the "data-free zone." The development of new problems with alcohol or other drugs among existing addiction staff may be rare, or it may be more common than anyone in the field might imagine. If relapse by recovering professionals is a subject often untouched, the development of new problems receives even less attention.

While many recovering professionals may consider their recovery an appropriate topic for discussion in employment interviews and supervision sessions, many people not in recovery consider their use or abstinence a personal matter. They may have mixed feelings about it, and hesitate to discuss their own choice to drink or use other drugs, even if their use has not reached the level of risk, consequences, or dependence. Among those who have progressed to substance use disorders, the level of secrecy is often high.

One central challenge in identifying the scope of this issue lies in its definition: Where does "partying" end, and where do "problems" begin? We live in a society that, while it stigmatizes addiction, also normalizes-and even glamorizes-the controlled use of alcohol and other drugs.

Participants could not define the scope or extent of the "partying" that takes place after hours at professional conferences in the field. In the field's history, reaching back before alcohol- and drug-related disorders were considered or treated together, there was a fairly substantial tradition of drinking and drug use at professional conferences. Some participants asked how much of that tradition might remain.

Participants also acknowledged that many professionals in the field have friends and acquaintances for whom alcohol and other drugs play key roles in their social systems. Some staff members who were raised in families affected by addiction might not have a clear sense of appropriate or "normal" vs. inappropriate behavior. If they are not in recovery, they might have no qualms about spending social time in situations in which alcohol and/or other drugs are the norm. Participants could only speculate about the effects of these appearances on community perception of the treatment organization or the field as a whole.

One group also touched on the likelihood that many treatment staff were raised in troubled families, and on the range of counterproductive attitudes and behaviors that can be fostered in these families. Even employees who have not themselves become addicted may have serious issues that affect their interaction with clients and fellow team members. The fact that they escaped addiction themselves might also mean that they were never forced to address some of these issues.

Participants identified clinical supervision as the most appropriate mechanism for identifying, addressing, and resolving these and a number of other problems. However, in many cases, supervisors may not be aware of AOD-related incidents that occur within the community, up to and including DUI arrests or the need to seek treatment. Supervisors might also be unaware of the extent or impact of family-of-origin issues on staff dynamics or service quality. These issues are difficult to quantify and address, and confidentiality is critical.

Participants cited the need to:

- Look at employee behavior and its impact on the workplace
- Measure the impact of employee behavior against codes of ethics and agency policy
- Help supervisors set appropriate boundaries for staff

Use, Misuse, and Abuse of, and Dependence on, Prescribed Mood-Altering Medications

On this subject, participants found it more difficult to define terms and reach consensus, for a number of reasons:

- Again, no empirical data exists, and participants suspected these problems are not reported or addressed consistently.
- Applied to prescribed medications, the term "mood altering" can fit a wide variety of drugs (e.g., antihistamines, antidepressants, opioid pain medications, amphetamines prescribed for attention deficit disorder). At some point in their careers virtually all addiction professionals receive prescriptions for medications that fall within this broad category.
- Judgments about use, misuse, abuse, and dependence can grow complex when one considers the appropriateness of the prescription and the prescribed dosage. The use of the term "dependence" may also be inappropriate and pejorative if it is applied to, for example, antidepressants or antipsychotics prescribed appropriately for long-term use. There are many prescribed medications that treatment organizations should not directly or indirectly discourage employees from taking.

- The difficulty of treating severe pain adds an element of complexity to discussions of opioid pain medication use, misuse, abuse, and dependence. What other pain-management options are available? What constitutes dependence in cases of severe chronic pain? Under what circumstances might these issues be different for employees in recovery, and for employees in recovery from opioid addiction?
- Definition of the term "relapse" grows more difficult when the substance being used has been prescribed for a legitimate medical condition, and especially when that substance is being used as prescribed.

Participants agreed that much more work is needed to address all these complexities; to define the necessary terms; and to establish guidelines for distinguishing legitimate use from misuse, abuse, and dependence. Guidelines are needed to help recovering people manage their medication in responsible ways. Organizations also need clear policies for the safeguarding of staff members' mood-altering medications in areas where clients might otherwise gain access.

As they did in response to the previous two questions, participants also emphasized the need to focus on behavior in the workplace, and on the measurement of that behavior against existing policies and ethical codes. Potential solutions to these and other issues are discussed in greater detail in Chapter Three.

SHOULD RECOVERING STAFF BE TREATED DIFFERENTLY?

Participants' next task was to map out any differences in the ways in which organizations and their leaders tend to respond to recovering and non-recovering staff. They were asked to discuss the differences in: (1) the requirement for abstinence; and (2) the consequences of the use and/or abuse of alcohol and other drugs between:

- Addiction professionals who publicly affirm that they are in recovery and
- Addiction professionals who publicly affirm that they have no problems with alcohol or other drugs, and those who evade the issue.

Participants cited a number of difficulties and complexities they faced in discussing these issues:

- Differences in the definitions of terms such as "recovery" and "relapse" may again pose obstacles in these discussions.
- It is essential to determine which problems might legitimately be related to lapses in recovery status. Does this apply only to resumption of AOD use, or also to disruptive behavior patterns related to a lack of self-care and attention to personal recovery? (It is not uncommon for people working in the addiction

field to interpret their work with clients as "12th-step work," and to use that interpretation as a rationalization for neglecting self-care.)

- Policies in this area are often inconsistent from organization to organization, and often inconsistently followed within a single organization. Standards may also vary in different types of treatment settings (e.g., medication-free treatment, methadone programs, therapeutic communities, DUI programs).
- The question of whether or not employees are treated differently based on their recovery status is often followed immediately by the question of whether or not, or in what ways, they should be treated differently. Does their higher level of vulnerability to these substances justify stronger vigilance on the part of supervisory staff?

There was a fair amount of consensus that recovering staff are treated differently from non-recovering staff, although policies might dictate otherwise. Participants affirmed that recovering staff are often under higher levels of scrutiny and supervision. They may be passed over for promotions because of assumptions based on their recovery status. Changes in mood or problems in performance or behavior may raise suspicion or be interpreted as relapse patterns, while the same changes or problems might be overlooked in non-recovering staff.

Participants also said that problems and possible relapse signs tend to be overlooked more often in high-value and long-term employees, regardless of recovery status. This can result in discriminatory treatment, with all the resulting damage to employee trust, team cohesion, and effective teamwork.

In considering and establishing standards in this area, it is essential to:

- Set clear and consistent standards and establish these as preconditions for employment
- Focus on whether or not the use of alcohol or other drugs causes impairment in job performance
- Take into account the impact on community perceptions of treatment and of the treatment organization
- Ensure that the standards provide protocols for intervening effectively in the event of relapse, rather than simply terminating employees who relapse

This exploration of the problem left participants eager to tackle the next phase of discussion: ways of addressing these challenges. That is the subject of Chapter 3.

CHAPTER 3: ADDRESSING THE CHALLENGES

CHAPTER 3: ADDRESSING THE CHALLENGES

The complexities involved in alcohol and other drug (AOD) issues among addiction professionals require a multi-faceted response. Throughout the Symposium Series, participants kept in mind the Twelve Core Needs they had identified on the first day of the first symposium:

Elements Needed to Inform This Process

1. Research Data
2. Needs Assessment

Overarching Considerations

3. Standards
4. Fair Labor Laws
5. Privacy
6. Non-Discriminatory Policies and Practices

Areas of Policy and Protocol

7. Hiring Policies
8. Competency-based Evaluations
9. Supervision Best Practices
10. Training and Mentoring
11. Wellness
12. Impairment Policies

Near the end of the first symposium, participants developed some ideas for projects that would begin to meet the Core Needs, with the commitment to pursue these or other relevant projects in the time between the first and second symposia. Although the schedule of the second symposium did not permit presentations on these projects by all participants, six people did address the group on their progress thus far. Their information is summarized in the "Project Highlight" boxes throughout this chapter. A list of all the project ideas identified during the first symposium is provided in Appendix A, "The Twelve Core Needs and Proposed Projects."

The remainder of the discussions in both symposia focused on possible solutions to alcohol- and other drug-related problems among addiction professionals. The results of these discussions fell naturally under eight categories, which also provide the structure for this chapter:

- Leadership
- Policy Options
- Employer Expectations
- Interviewing and Hiring Practices
- Privacy and Non-Discrimination
- Supervision and Corrective Processes
- Support for Policies
- Employee Wellness

Leadership

Participants realized that an effective response to these issues first requires effective leadership. They articulated a strong need for mature and experienced leadership, given the complex, subtle, and sometimes seemingly contradictory aspects of this problem.

They affirmed the importance of fair labor laws, but emphasized the even greater importance of consistent application of these laws to the realities of clinical practice. It is the responsibility of leadership and management within the treatment organization to:

- Learn about all applicable laws and standards and the ways of applying them fairly
- Set appropriate policies, procedures, and administrative protocols
- Provide consistent education on and enforcement of existing policies, procedures, and administrative protocols
- Model appropriate behavior in their work and in their lives

Board members should follow the same policies as employees within the organization. The Boards also can and should be a valuable resource in addressing these issues. Board members should be willing to listen to employees and truly interested in the realities at work in the organizational culture.

In their adherence to federal, state, and local laws, organizational leaders must ensure that their policies and actions are consistent with the organization's mission, vision, philosophy, and ideals. In general, the profession needs more training in fair labor law, and in the integration of the letter, spirit, and intent of this legislation into routine practice. The application of these laws should be used to benefit clients, staff, organizations, and communities.

Policy Options

Along with specific policies that organizations may adopt, participants also addressed the qualities of appropriate policies and the most effective ways of establishing and implementing them. They made the following recommendations:

- Organizations must take care to make policies, procedures, and practices nondiscriminatory, and to relate them to the expectations and responsibilities of all employees.
- Policies must be realistic, and must be created in the spirit of employee growth and development. There is no appropriate place for policies that are harsh, punitive, applied suddenly with adverse consequences, or applied without any opportunity for correction of the problems they seek to address.
- Policies must provide escalating consequences, in a sequence of interventions matched to the situations at hand. There will be some extreme circumstances under which more extreme or punitive consequences might be appropriate, but in many situations the most appropriate interventions would be more therapeutic in nature. In effect, what is needed is a protocol for step-wise continuity of care for employees.
- The field must be careful to avoid "geographical ethics," situations in which employees who behave in ways considered unethical in one organization or region can simply transfer to another location in which inappropriate behavior will be tolerated.
- These issues must be addressed in policies, but the policies must also become part of the living culture of the organization. They cannot be reduced to manuals that sit on the shelf, to be dusted off only in preparation for regulatory surveys.

- Personnel policies should include:
  - Professional development plans that define career paths and help employees move ahead in these paths
  - Training plans that bring employees up to minimum standards in required areas of professional practice and team participation
  - Measures for corrective discipline, designed to correct problems and bring employees back into good standing, rather than to entrap employees and facilitate termination

During the course of the discussion, participants identified a number of types of policies and standards that an organization can set within the constraints of the law. These include the following:

- Organizations can and should establish hiring standards, including the uniform bona fide occupational qualifications (BFOQs) that are necessary to carry out job responsibilities effectively. These might include things like abstinence or moderation in the use of alcohol.
- Drug-free workplace laws already provide a uniform policy prohibiting the use or possession of illegal drugs in the workplace.
- Organizations can provide for drug testing of staff (applied uniformly, regardless of recovery status) and for referral of staff who test positive to medical personnel or employee assistance programs (EAPs).
- An organization can prohibit its employees from drinking on the job or during lunch hours. In some occupations, employees (e.g., airline pilots) are not allowed to drink alcohol for a consistent number of hours before they begin their shifts. In the airline industry, the standard has been abstinence for eight hours before work, recently increased to 24 hours. There was some speculation about the legality and appropriateness of applying a similar standard to this profession.
- Treatment organizations can dictate the need for supervision if an employee's performance on the job is suspected of impairment. The key here is the focus on the impairment of performance itself, rather than on the source of the impairment, whether that source might be alcohol, illegal drugs, or prescription medications.
- Organizations need policies and guidelines for employees in managing prescription medication in the workplace, particularly in the protection of clients from the temptation they might experience if they see these medications in employees' work space. This issue has also been addressed in recent CARF (Commission on Accreditation of Rehabilitation Facilities) surveys.

- An organization might impose a ban on prescription medications that impair judgment, performance, or communication.
- An organization can be more stringent in setting policies and BFOQs for counseling staff, given the greater need for effective relationships with clients and the greater potential for harm.

It will be necessary to develop addiction-profession-specific standards that provide uniform guidelines for the program manager and director, guidelines that can support these administrators if they are forced to make difficult choices and violate cultural taboos within the profession. These policies should be created within a broad-brushed approach that identifies the range of problems that might exist and includes EAP assistance for evaluation and referral of any problems that surface.

Occupational Tools Include (but are not limited to):

- Employee selection procedure
- Pre-employment work agreements (including professional codes of conduct and ethics both on and off the job)
- Staff orientation materials
- Effective use of the probationary period and probation extension with cause
- Daily on-the-job training
- Mentoring programs
- Formal performance evaluations
- Systematic corrective discipline procedures
- Referral to formal EAPs at every step of the corrective discipline process
- Outplacement counseling (including referral to treatment for those in need, when termination is required)

Project Spotlight: Federal Guidelines and Impairment Policies

Participant Arnold Evans reported to the group on his review of relevant guidelines and policies, most notably the Americans With Disabilities Act (ADA), the Health Insurance Portability and Accountability Act (HIPAA), and the Drug-Free Workplace Act. He also discussed some implications of these policies.

The ADA has several implications for employers' decisions regarding the rights of employees in recovery. That Act was designed to protect the rights of people with disabilities and mandate reasonable accommodations necessary for people to obtain and maintain gainful employment. "Reasonable accommodations" are measures that make sense and are affordable within the constraints of the organization. (See Page 31 for further discussion of reasonable accommodations.) Recent court decisions have limited ADA protection for people with SUDs to those who are in recovery and not still using illegal drugs or misusing prescription drugs.

It will be essential to establish criteria for determining "reasonable suspicion" of relapse. If an employee's behavior patterns vary from his or her own norms in negative ways, the employee will need referral to an outside resource to determine the nature and extent of the problem. Whether or not the relapse affects on-the-job behavior and effectiveness, and whether or not an employer can prove this impact, are also essential considerations.

For those cases in which employees do relapse and seek treatment, it is important to have consistent standards for the length of time that must pass before they are able to resume counseling duties. Some other professions have prescribed time-periods for employees returning to work after treatment. For example, nurses are required to be alcohol and other drug free for five years before returning and must be monitored after their return. In addition, it is necessary to determine both the length and the quality of recovery necessary before a staff member can be an effective counselor.

If employees bring illegal drugs (or illegally used prescription drugs) into the workplace, or report to work impaired, their actions violate the Drug-Free Workplace Act, whether or not they are in recovery. Responses to recovering and non-recovering staff should be the same in these cases.

When addiction is addressed appropriately, as the medical condition that the best-respected bodies (e.g., the American Medical Association, the American Psychiatric Association, the American Society of Addiction Medicine) have deemed it to be, the privacy of people with this disease is protected by the Health Insurance Portability and Accountability Act (HIPAA). It is the employer's responsibility to maintain compliance with HIPAA standards.

Employer Expectations

Participants made it clear that employers are responsible for setting appropriate and realistic expectations in this area and articulating these expectations clearly in policies and in job interviews. Expectations cannot be presented for the first time after the employee has accepted the job, or after the expectations have been violated. The employee's responsibility is to take all these expectations under serious consideration in deciding whether or not to accept the job and to live up to all standards set forth for the job that he or she has accepted.

The organization's policy and procedure manuals must include an outline of each position, including all requirements, qualifications, and expectations. These must be packaged in text that meets all the tests required, including those imposed by regulatory, statutory, and internal policies. Each job description should clearly describe the functions associated with the position, the responsibilities of the position, and the general codes of conduct that apply during working hours and non-working hours. One key is a focus on fitness for duty and the mental, emotional, and AOD-related requirements that are necessary to ensure that an addiction professional is fit for duty.

To some extent, science-based practices can provide a framework for the development of effective clinical skills, and so serve as a form of support for healthy professional practice. Wherever possible and appropriate, employers should set the clear expectation that treatment processes will follow science-based best practice, use proven approaches, and be effectively supervised. However, employers should also allow sufficient freedom for the use of the individual clinician's judgment and the development of an individual therapy style.

Some participants identified a tendency among some organizations to set unrealistic rules and expectations, up to and including harsh and punitive standards, and then to bend these rules. If the policy is unworkable or poorly written, the organization may tend to "operate by exception," thus turning exception into de facto policy. Instead, employment expectations must be realistic and fair. They must match the level of the job (e.g., management vs. staff), the professional experience and education of the employee, the duties required, and the employee's capacity to inflict harm during the course of work. In addition, expectations must be applied consistently and uniformly.

Participants noted the need for caution that these expectations not arise out of stigma, stereotypes, or unrealistic notions of what an addiction professional should be. They acknowledged the level of stigma within the larger societal culture and the power of that culture in influencing employers' subjective judgment. They also affirmed the field's responsibility to counter stigma within the larger culture, for the sake of organizational health and the general well being of clients and people in recovery.

Interviewing and Hiring Practices

Organizations take a variety of approaches toward identifying (or not identifying) people in recovery (remission from SUDs) during the interviewing process. Most employers (one participant estimated 90%) use unstructured interview processes, the least reliable way to identify potential issues and document these issues for any future disputes. Employers are not allowed to ask about alcohol use or to ask if a prospective employee is in recovery.

However, there are many subtle and not-so-subtle ways for a candidate to communicate (or an employer to infer) recovery status. If the organization has established standards of wellness and behavioral health as BFOQs, interviewers are allowed to ask questions relevant to those standards, and to obtain written commitment to those standards from prospective employees. In addition, an employee who is taking any prescription medication that impairs thought or judgment is required to inform prospective employers of this fact.

The group discussed the existence of unwritten policies and procedures within the field, understandings that aim more toward the spirit than the letter of the law, and the difficulties that can arise in their interpretation and application. Unwritten rules are effective only to the extent that people perceive them equally and apply them fairly, and their unwritten nature makes this impossible to ensure and monitor.

Random drug testing of staff is an area in which the groundwork must be laid in the interviewing and hiring processes. Prospective employees must be told directly that they will be subject to random tests and sign an agreement stating that they understand and agree to submit to these tests. However, testing must be truly random, and it is suggested that the agency have an outside source both select employees for testing and perform the tests.

Project Spotlight: Employment Policies on Interviewing

Participant T.J. Elison's project was a PowerPoint slide show and a collection of supporting documentation, all available on CD. These materials take the reader through a process of developing an internal administrative policy on interviewing that addresses many concerns discussed at the symposia, including a sample Employee Handbook. Among the topics addressed are:

- Limitations on the questions an employer is allowed to ask a candidate, and the laws that govern these limitations
- Standards for clarifying bona fide occupational qualifications and requirements for communicating these to prospective employees and new employees (e.g., in the job description)
- Civil rights aspects of these issues, including implications of the Fair Labor Standards Act
- Implications of the Americans with Disabilities Act (for organizations with 15 or more employees)
- Requirements for circulating written drafts of policies and procedures and obtaining commitment from all employees
- Job descriptions
- The development of employee handbooks
- Performance counseling and corrective action
- Referral to Employee Assistance Programs (EAP) and the responsibilities of EAPs

Privacy and Non-Discrimination

The issue of employee privacy made for a somewhat more complex discussion due to the dual nature of this issue: It is both a "hard" issue, with legal and behavioral components, and a "soft" issue, rooted in that which is unspoken.

In employment interviews, employers cannot legally ask about recovery status, except to ask if the candidate has any health problems or illnesses that will interfere with job performance. However, an organization can establish BFOQs that would apply appropriately to both recovering and non-recovering staff, and can ask prospective employees if they meet these qualifications.

Participants were uncertain of the limits the treatment organization must respect in establishing BFOQs. For example, if abstinence or moderation in AOD use is a qualification for effective counseling practice, and that qualification is applied uniformly, is it appropriate to ask about it in a job interview? Can self-care be considered a legitimate qualification for effective service? If so, is this an appropriate subject for an interview question? One challenge that arises during the interview process is the need to collect information that will help potential employers determine an employee's need for supervision. What questions are appropriate for the interviewer who wishes to address this challenge?

The existing body of knowledge on management systems, combined with law and case history, provides a strong foundation to help the field develop its own standards. The task will be to review that body of information and to apply its principles to practical examples specific to the addictions field. A great wealth of information is available on management and supervision issues, ways of addressing these issues, and the general principles and uniform practices underlying them.

When factors that might affect job performance are not disclosed during an employment interview, this sets the stage for a loss of trust in the employee, should these issues reach the surface. Participants agreed that it would be inappropriate to require employees to disclose many aspects of their lives during the interview process, but that certain forms of disclosure (e.g., information on criminal background, certification, classification, history of violence, or medical conditions that would interfere with performance of duties) must be required uniformly of all prospective employees.

Participants affirmed the need to protect the privacy of addiction professionals. By the same token, they emphasized the primary importance of client safety and effective treatment and the importance of sober, responsible behaviors within the treatment organization and the community. If an employee keeps his or her behaviors (e.g., AOD use) private by avoiding impairment and irresponsible behavior, the employee's privacy will automatically be protected.

Project Spotlight: Balancing Privacy and Professional Boundaries

At the second symposium, Genice Hall-Summers was in the process of developing a set of resources on balancing personal privacy and professional boundaries. The ultimate product of this process will be a training that covers a number of topics, including:

- A workplace rights questionnaire, used as an icebreaker and a homework assignment
- Privacy and freedom from unauthorized intrusion, including discussions of:
  - Fraud and dishonesty in the application process
  - Concepts adapted from the National Association of Social Workers Code of Ethics
- Employee responsibilities when impairment is due to substance use issues and mental health issues that interfere with judgment
- The range of ethical issues involved in this area
- Standards and laws governing these issues, the differences in these laws from state to state, and the rights that these standards protect
- Role-play exercises centering on critical incidents and calling on participants to think about appropriate ways of responding

Participants also emphasized the importance of avoiding rigid or arbitrary standards that do not leave room for differences in circumstances, effects, levels of impairment, and performance issues. TAP 21 can help the field weigh the issues and determine which issues are truly related to performance of clinical duties and effective team membership.

Issues of privacy and non-discrimination (against recovering staff) often seem to go hand in hand (e.g., differences in treatment of recovering and non-recovering staff, appropriate responses to relapse in a counselor, self-identification among employees who show no job-related impairment). In a sense, recovery might be considered a subculture in itself, a consideration that transforms this into a discussion of multicultural issues.

Participants affirmed that the treatment organization can and should ask and address anything that is relevant to the integrity of the profession, within the constraints of the law. In the words of one participant, the factors that employers are not allowed to ask about are clearly stated within the law, and it is this field's responsibility to research and use all applicable information from the law. Anything not prohibited by law is fair game.

In the end, it is a contest between the employee's right to privacy and the client's right to safe and competent services. When potential employers consider a counselor's fitness for duty, how can they not ask these questions?

Frequently in discussions of non-discrimination, participants returned to the importance of establishing and communicating bona fide occupational qualifications (BFOQs) as a way of tying behavioral requirements to uniform standards for all employees, rather than to individual employees' recovery status. Participants identified a few issues that BFOQs should address, including:

- Behavior regarding alcohol and other drug use within the community
- Relationships with clients and former clients, on the job and in the community
- Training and credentialing (often an issue for clergy in faith-based treatment programs, who are not required to seek addiction-specific training or credentials)
- Any skills that require special training and credentialing
- Employees' therapeutic issues
- The effects of any medical conditions that interfere with effectiveness

Supervision and Corrective Processes

Many employee issues tend to fall to the clinical and administrative supervisors for identification; assessment; corrective measures; and referral to higher levels in the organization, or to Employee Assistance Programs. The supervisor plays an essential role in protecting both the rights of the employee and the safety of the client.

Participants took care to point out the difference between supervision and therapy-and the importance of maintaining that distinction. When employees have problems that are not addressed through more appropriate means, supervisors can be drawn into counseling roles with the employees they supervise. Like any "dual role" situation, this can present significant problems.

One participant reminded the group of the wealth of resources on this topic available in TAP 21A: Competencies for Substance Abuse Treatment Clinical Supervisors, SAMHSA/CSAT's new Treatment Assistance Publication.

Organizational policies should have provisions for addressing the possibility of relapse among recovering staff through a comprehensive intervention process, rather than immediately terminating employees, as is so many organizations' tendency. These protocols might follow the standard "Fitness for Duty" criteria described in other types of workplaces, in which an individual is assessed, evaluated, and treated, with the intent to restore that individual to productive working status. No arbitrary time-frames should be established. Rather, these individuals should be addressed on a case-by-case basis.

Project Spotlight: Best Practices in Clinical Supervision

Von Wrighten presented the results of his project, a set of guidelines for best practices in clinical supervision. He began his project with an informal survey, asking respondents to define clinical supervision (and determine which practices do or do not constitute clinical supervision). Other components of the project included an examination of some of the ethical implications of clinical supervision issues; identification of the impact of supervision; and recommendations for clinical supervisors, provided by a committee convened for this purpose.

The survey yielded a number of interesting results. For example, many respondents were confused about the distinctions between clinical supervision and administrative supervision, and many reported people crossing the boundaries between the two. Although these two roles naturally overlap, the ideal is to separate clinical from administrative supervision. Administrative duties often take precious time away from clinical duties, and many staff members find it more difficult to speak openly of clinical and personal challenges with people who have the power to take disciplinary action.

Managers surveyed said that that effective supervision was helping some people in recovery acquire a broader scope of skills beyond those acquired in recovery. They reported high levels of improvement in all staff who were supervised, including improvement in clinical skills. They emphasized the importance of the supervisory relationship. When supervisors had inadequate knowledge of recovery, or of the components of good supervision, this had a negative impact on the supervisory relationship and the success of supervision.

Only 20% of respondents said that people in recovery required specialized supervision because of their recovery status.

Recommendations submitted by the committee included the establishment of regular times for supervision, the separation of and delineation between administrative and clinical supervision, the articulation of consistent goals for supervision, the removal of barriers to supervision (with the shortage of funds as one of the largest barriers), and a clear understanding of clinical needs at all levels of the organization.

Support for Policies

As many participants noted, a policy manual sitting on a shelf has only limited power. To be effective, policies on emotional and behavioral health issues must receive support from all organizational levels.

Whenever possible, staff interactions should be guided by effective, science-based communication, problem-resolution, and team-building processes. Employees should receive notification of and training in these and other areas before being held accountable for them. Effective supervision is also essential to the effective application of policies and procedures.

These issues are best addressed within the context of general individual and organizational wellness. The agency needs an integrated process for employee selection, orientation, on-the-job training, stress management, supervision, employee feedback, formal standards for probationary status, and corrective discipline. All of these elements should be tied to employee wellness, team functioning, and employee assistance programs. Management of AOD issues must be integrated with management in general, and with the management of employees who experience problems that affect their job performance or team participation.

Of primary importance is the establishment and organization-wide support of higher standards for therapy staff, whether or not those staff members are in recovery. This high standard of sober and responsible behavior must be applied consistently to communication with other staff, conflict resolution, relationships with clients, management of routine client care, and the resolution of client-management issues.

Both recovering and non-recovering staff should be expected to create and maintain an AOD-free workplace; model clear-minded, sober, responsible, courteous, and professional conduct; and foster effective and trustworthy relationships with colleagues and clients. These should be considered the minimum requirements of therapeutic staff. If employers and the field as a whole focus, not on recovery status, but on the standards to which addiction professionals must be held, all other issues will gain clarity and perspective.

Promoting Employee Wellness

In a field whose demands are often not conducive to self-care, the needs of recovering staff provide a legitimate challenge to the prevailing "do more and more with less and less" approach toward meeting those demands. In many cases, the ultimate consequence of neglect of self-care would be a relapse to active addiction. However, wellness can be a difficult commodity to assess and address. Given that organizational wellness is also an essential component in supporting individual wellness-and often a difficult one to achieve-organizational leaders are also responsible for addressing organizational wellness issues in effective ways.

When it comes to wellness, the natural inclination is to think in terms of providing education and support. However, all too often the information gathered at workshops makes its way to the shelves, where it remains until it is moved over to make room for the manual from the next workshop. What is needed instead is a holistic program that looks at wellness on many dimensions and helps people implement the practices they have learned. Team-building efforts are essential follow-up to wellness training programs.

Discussions of the ADA provisions brought up the concept of "reasonable accommodations" that make it possible for people with disabilities to work. What accommodations might be necessary to promote wellness and continued sobriety among people in recovery?

- An understanding of the need-and provision of opportunities-for participation in community-based recovery support programs
- Fully functioning EAPs
- Education of non-recovering staff (e.g., supervisors and direct reports) in cultural competency regarding their recovering peers (e.g., "practicing what we preach," stigma-reduction efforts within the organization, not bringing personal biases to work)
- Full integration of recovering employees into the professional treatment culture, healing the existing split between recovery and professional approaches
- Creation of organizational environments in which recovering staff feel secure speaking openly of their recovery status, allowing for easy and open discussion and a reduction of tension and stress around these issues
- Involvement of recovering staff in the development of policies and procedures related to their status and issues

The empathic, collaborative relationship with the client, so essential to effective counseling, is also essential to practitioner wellness. Counselors are responsible for maintaining resiliency and avoiding "depleted care," the incidence of compassion fatigue and burnout. Factors that can lead to depleted care include work overload; lack of control; insufficient rewards; a breakdown of the sense of community in the workplace; a lack of fairness, respect, or justice; a lack of meaningful, valuable work; and unaddressed or unresolved conflict.

Wellness requires a balance between self-care and care for others. The emphasis on selflessness and sacrifice in the helping professions can sometimes hamper self-care and appropriate rewards for work well done, and can diminish people's sense of self-worth and appreciation of their gifts.

Project Spotlight: Workplace Wellness Survey

As his project for the Symposium Series, Arthur Logan had administered a workplace wellness survey to ten clinical counselors treating substance use disorders, then tabulated the results. Some of his findings:

- Asked if they believed they were having adequate sleep, only 30% answered "frequently," and 70% said "sometimes" or "rarely."
- Only 10% said they "always" had enough exercise, with 40% saying they "frequently" had and 40% saying they "sometimes" or "rarely" had enough exercise.
- The majority responded that they had proper nutrition.
- 80% said they were managing stress effectively.
- 60% said they needed more leisure time
- 70% said they felt spiritually connected
- 70% said they "always" or "frequently" were able to solve their personal issues
- 70% said they "frequently" received good supervision
- Only 10% said that workplace policies were "always clear"

For more information on this survey, you may contact Mr. Logan at arthurl@clemson.edu.

Wellness also requires an enhancement of one's own potential. Some skills necessary for wellness include sensitivity to others and their feelings, perspective, empathy, understanding, tolerance of ambiguity, and an ability to accept and use constructive criticism.

Some challenges to counselor wellness include the seemingly unsolvable problems that clients can bring, lack of cooperation by clients, motivational conflicts and power struggles (particularly if the counselor lacks effective motivational skills and engages in these conflicts), the counselor's awareness that he or she lacks some of the qualities the client needs, inability to say "no," and the natural levels of fatigue that come from constant interpersonal sensitivity.

Measures that can help counselors fulfill their responsibility to self-care include taking structured time, effective communication, skills for managing stress and conflict, proper nutrition, exercise, personal growth, leisure time, sufficient rest and sleep, and self-renewal activities and rituals.

The workplace can enhance wellness through the provision of effective supervision; clear and appropriate policies that are maintained and enforced fairly; an atmosphere of fairness, respect, and justice; sufficient resources and an adequate physical plant; manageable work loads; conflict-resolution training and support; mentoring and peer support; opportunities for recognition and reward; effective diversity training and follow-up; and retreats and other opportunities for rejuvenation.

Project Spotlight: The Addiction Fellows Program

Jim Van Hecke addressed the group concerning the North Carolina Addiction Fellows (NCAF) program that he had initiated at his organization to address wellness issues. Clinical staff were evidencing signs of burnout and frustration, overwhelmed by emotion and feeling the lack of esteem from their colleagues and others outside the field.

The organization had experienced a 100% turnover of staff in three or four years. Demographics had changed from a predominantly recovering staff to a group of employees who had entered the field for a variety of reasons but lacked the passion that the recovering staff had shown for their work.

The aim of the Fellows Program was to improve retention and reinstill passion. It was designed to address fundamental issues such as the lack of connectedness, the lack of respect, and the need for effective training in the field. What the program's organizers did not expect was the hunger for connectedness and for opportunities to discuss these issues that many staff were experiencing, or the extent to which this experience of community would transform staff members' lives.

Of the 59 people originally enrolled in the program, one died, one could not complete the program, and 57 are still working in the field. They have experienced renewed passion and have built a network and email system that is still keeping them in contact with one another every day, and they are providing support to one another through difficult situations and life transitions.

In the next phase, the program's organizers will prepare the original 57 people to act as faculty and staff, acting as mentors for others in the field, and will begin a similar program in South Carolina.

Next Steps

The need to protect both the safety of clients and the rights and wellness of staff is significant, and the issues that surround it are far too complex to be addressed in two short events. Participants left the second symposium determined to see the process of discussion and development continue and expand.

One idea that arose during the second symposium was the prospect of having other Addiction Technology Transfer Centers (ATTCs) hold similar events in their regions. In the Request for Applications for the next five years' funding for the ATTCs, the Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment supported this concept by offering to fund special projects related to alcohol and other drug use within the treatment field.

It is the hope of the participants, sponsors, and facilitator that the work that takes place in the future will build on what has been accomplished in these forums. The ideal would be a process in which each ATTC Region uses the lessons learned and progress made in the Regions that have embarked on this journey before it, customizing this material to its own needs, but avoiding duplication of effort.

What is also greatly needed is a national response to these issues, a set of standards and resources that states and regions can contribute to, build upon, and hold before them. The national emphasis on Recovery-Oriented Systems of Care will require-among many other measures-a thoughtful and innovative response to the recovery needs of treatment staff and the preservation of safe and effective treatment and recovery support services.

APPENDICES

APPENDIX A: THE TWELVE CORE NEEDS AND PROPOSED PROJECTS

Through a process of prioritization and synthesis, participants at the symposium distilled this information into 12 core needs, and crafted language to articulate those needs.

Elements Needed to Inform This Process

1. **Research Data:** We need research data on the prevalence, extent, and effects of impairment within the addiction profession. This includes an operational definition of impairment that is broad based and not restricted to AOD use.
    - EXPLORATION OF COLLABORATION WITH RESEARCHERS: To help bring this inquiry out of the data-free zone, one participant volunteered to explore the feasibility of collaboration with the services research field, to gather concrete information about the prevalence and impact of alcohol and other drug use by professionals in the field. The services research field focuses on applied research, and on determining better ways of providing services. With the help of contacts made through the National Institute on Drug Abuse Clinical Trials Network, this participant will work to determine some appropriate research questions, conduct a brief literature review, and determine the need and opportunity for the gathering of empirical data.
2. **Needs Assessment:** We need to complete comprehensive needs assessments to determine current practices; evaluate their effectiveness; and identify factors related to successful professional practice, and those related to practices that lead to impaired performance. We need to determine the needs that must be met in order for addiction professionals to function at optimal levels of performance.

Overarching Considerations

3. **Standards:** We need to establish national, regional, and local standards on impairment and EAP practices for the addiction profession, and produce an authoritative resource guide. We need to join forces with other agencies and professional groups to accomplish this goal.
4. **Fair Labor Laws:** We need to ensure fair practices compliant with fair labor laws in all states. We need to unify fair labor practices under national and international standards.

- GUIDELINES FOR INTERVIEWING AND HIRING: The goal of this project will be to present to each hiring manager specific guidelines, including interviewing standards, the evaluation of expectations, uniform handling of performance issues, and ways of balancing all these elements. To this end, the participant will gather existing data on legal issues, interviewing practices, job descriptions, employee handbooks, workplace policies, and counseling approaches.

5. **Privacy:** We need to define ways of balancing personal privacy with professional duties, responsibilities, and obligations.

   - POLICIES AND PROCEDURES FOR DISCLOSURE: This document will include policies and procedures on disclosure of elements such as recovery status and AOD use, guidelines for exceptions, and consequences for non-disclosure. In preparation, this participant will identify areas of personal behavior that may have adverse impact on an employee's performance, the reputation of the service provider or the profession within the community, and any negative or conflicting messages that their behavior might send to the client or the community. Procedures will address appropriate responses to employee behavior, keeping in mind the best interests of the client, the organization, the community, and the profession.

   - RESOURCE TOOL AND IN-SERVICE FOR INCREASING BALANCE AND EFFECTIVENESS: This resource tool will be designed to increase the effectiveness of addiction professionals, helping them balance their personal privacy with their professional duties, responsibilities, and obligations. It will identify these professional duties, responsibilities, and obligations in accordance with TAP 21 (The Addiction Competencies established by the Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment). This participant will use the dictates of law and a fair labor survey of professionals in the field to define personal privacy and delineate its appropriate boundaries. Based on this information, the participant will compile a document and/or a training, including an in-service education outline, to serve as an educational resource for supervisors and supervisees in the addiction field.

6. **Non-Discriminatory Policies and Practices:** Organizations should develop non-discriminatory policies and procedures that prevent and manage problems that might be experienced by addiction professionals. These include: (1) a consistent code of ethics and (2) consistent hiring practices.

   - NON-DISCRIMINATORY POLICIES AND PROCEDURES: This project will begin with an assessment of current policies and practices in the field, including an analysis of their deficiencies and the ways in which they might discriminate against recovering staff. Naturally, this process will have to in-

clude a clear identification of the elements that should be included in such procedures, and the things that they are expected to accomplish. It will entail the development of language appropriate to address and remedy the issues identified in the assessment phase. The product will be a set of non-discriminatory policies and procedures that will enable an agency to effectively manage problems experienced by all staff who work in the profession. These will be accompanied by training for management, orientation for staff, and concrete tools to implement these policies.

Areas of Policy and Protocol

7. **Hiring Policies:** (1) These must be consistent with current federal, state, and local laws and agency vision, mission, policy, and procedures. (2) They should value life experience, professional experience, and academic credentials.

    - HIRING POLICIES AND PROCEDURES: In the belief that employment problems can often be traced to systems rather than to individuals, this participant opted to develop a system of effective hiring policies and procedures. These written standards would include procedures and forms designed to identify qualified personnel, to aid in the interview process, to collect information through application forms that meet all legal requirements, and to notify and instruct employees through standard operational procedures. Policies and procedures would clearly define processes for hiring, including advertising, taking applications, interviewing, performing background checks, and contacting references. Procedures would also address pre-hiring interviews, and articulate clear expectations.

8. **Competency-based Evaluations:** There should be a competency-based evaluation of core addiction treatment competencies. TAP 21 can be used as a guide. Organizations need to develop Bona Fide Occupational Qualifications (BFOQ) for each job category and provide proper orientation of all employees to all job-related expectations, vision, mission, policies, and procedures.

9. **Supervision Best Practices:** We need to develop written guidelines for Best Practices to guide supervision and professional practices.

    - GUIDELINES FOR SUPERVISION BEST PRACTICES: These guidelines would articulate the impact of supervision on preventing relapse in the workplace, and clearly articulate the differences between supervision and management, and between supervision and therapy. This project might began with an informal survey of managers in several agencies, collecting their impressions of current supervision and management practices, and their implications for employee behavioral health. It would also include a survey of research on current supervision practices, including multicultural supervision. The final project would include recommendations for best practices.

10. **Training and Mentoring:** Organizations should provide training programs for staff, administration, managers, supervisors, and line staff, with a strong focus upon orienting new employees so they can rapidly become effective in their jobs. These processes should become standardized on the agency level consistent with federal, state, and local laws and agency policies. Organizations should provide on-the-job training and mentoring programs to help people acquire the competencies necessary to do their jobs. Training is an ongoing essential because of the rapid change in environment and the need to address both "uncomplicated" addiction and addiction complicated by coexisting mental health disorders, legal problems, and social problems.

    - STANDARDIZED TRAINING MODULES: This participant opted to develop standardized training modules that will clearly define goals and objectives. These modules will focus on employee competence and improvement of performance levels. Elements will include clear definition of training goals and desired outcomes, and effective measuring of training outcomes using pre- and post-testing and evaluations. The participant will then teach a class following these modules.

11. **Wellness:** Organizations should develop wellness programs and practices to take care of employees, and provide effective supervision policies and practices that consider the wellness of the employees. These should include specific scheduled activities, including such things as retreats for the purpose of rejuvenation and burn-out prevention, peer support and mentoring practices, and "growth groups" to enhance professional development. These groups would be aimed at self-awareness and "spirituality recharge."

    - CORE NEED TRAINING AND WELLNESS WHITE PAPER AND PROGRAM: This participant's project will be a white paper on core need training and wellness. Its goal will be to expand a module that the participant has developed, with an exploration of new venues for expansion of this model. It will document key elements of success in mentoring programs to-date. The participant will also begin at least one new program based on this white paper.
    - SELF-ASSESSMENT PROFILE: This profile will be designed to help employees understand themselves, their assets, and their self-care needs, to encourage and facilitate greater wellness and more effective self-care. It will include a focus on knowledge of their own and others' self-management styles, enhancement of personal and professional interpersonal skills, and improved connections among people. This project will also explore areas and methods of change, and encourage employees to practice new methods of improving their skills. It will provide suggestions for elimi-

nating "baggage" and preventing overload. It will also include methods of using feedback from others for self-improvement.

12. **Impairment Policies:** We need practical and enforceable policies for addressing impaired professionals that reflect fair practices consistently applied to all addiction professionals and support staff. These policies should build trust and consistency in their application to staff at all levels of the organization. They should include wellness policies designed to prevent problems and remain consistent with professional and agency codes of ethics. They need to: (1) be enforceable, (2) be fair, (3) engender trust, (4) promote wellness, and (5) support high ethical standards. This includes the training of boards of directors, clinical management teams, physicians, and therapeutic and support staff.

    - IMPAIRMENT POLICY LINKED WITH SUPERVISION: This project will begin with an examination of the participant's own organization and its history in addressing these issues. Research will also include information from other successful companies that perform the same functions, including their policies. Staying within federal guidelines for hiring and supervision, the participant will modify existing policies as needed and appropriate, subject these policies to the organization's review process, and distribute the resulting policies to all supervisors and staff.

APPENDIX B: SAMPLE POLICY: PERSONAL CODE OF ETHICS

Note: *This sample policy was provided by Facilitator Terence T. Gorski.*

Rationale:

Effective functioning as a professional member of the _____ requires the development and maintenance of a public image of professionalism, responsibility, and credibility that installs public confidence in the _____ and in the profession of alcoholism treatment. Often these responsibilities exceed those that are leveled on other hospital employees.

The following statements of professional ethics have been implemented as policy within the_____ .

1. Every staff member accepting employment with the _____ must voluntarily agree to comply with the prohibition against being publicly intoxicated. Public intoxication is defined as any incident of alcohol consumption or use of mood altering substances that result in a public display of behavior commonly associated with intoxication. Violation may be subject to suspension or termination.
2. Any staff member arrested for the possession or use of any illegal drug, narcotic, or mood-altering substance may be subject to suspension until the case comes to a final disposition. If the final disposition is that of conviction, the staff member will be terminated from employment.
3. Any use of any illegal drug or mood altering substance that is witnessed by any member of the external public and reported to the _____may be grounds for suspension or termination.

Policy: Code of Ethics For_____Staff

4. The use of alcohol or any other mood-altering substance, including legally prescribed sedatives, is prohibited for any staff member who is on duty at the _____. This includes the use of sleeping medications the night before, sedative medication, and the consuming of any alcoholic beverages over meals. If sedatives are prescribed as a treatment for a physical condition, the special work environment of the _____may necessitate that this employee be unable to work due to medical reasons. Any person known to be under the influence or known to have taken any mood altering substances within a period of 8 hours prior to reporting to work will be asked to leave work

for the day and may face suspension or termination. Exceptions to this must be formally approved by the Director and Medical Director of _____. Violations may be subject to suspension or termination.

5. All _____ employees are restricted from conducting social relationships of any kind with clients and or their families who have been treated by the_____ Exceptions to this policy must be approved and documented by the service section Coordinator prior to the initiation of the social relationship. The primary exception to this policy will be where there is a relationship that was established prior to the client's admission.
6. Members of Alcoholics Anonymous and Al-Anon will see clients at open and closed meetings. This is approved, but, without written approval, any contact over and above that involvement may be prohibited. No staff member who is a member of Alcoholics Anonymous or Al-Anon shall become a sponsor to any discharged client or family member unless that relationship of sponsorship was firmly established prior to admission of the client to_____. This relationship must be made known to the appropriate Coordinator of Supervision at the time of the client's admission.
7. All staff members are bound by the restrictions of Federal Confidentiality Legislation as described by the Company Policy. Violations may be subject to Suspension or termination.
8. A professional dress code exists for all members of the_____. This dress code stresses professional appearance that will lend credibility and respect to the COMPANY. Suits and ties or sports coats and ties are appropriate for male staff. Dresses, skirts, and pantsuits are appropriate for female staff. Attire that is sexually provocative will be avoided. Blue jeans are inappropriate attire for any staff member.
9. Staff members are strongly encouraged to participate in professional organizations, voluntary services, and speaking engagements that enhance their personal prestige and that of the_____. Public presentation of material that contradicts the stated philosophy of the_____ is strongly discouraged.
10. In accordance with _____ Policy, staff will not accept gifts, tips, or extra remuneration from clients, nor will they accept personal liability for outstanding client fees.

I acknowledge that I have read and understand all aspects of the Policy:

Code of Ethics for _____Staff. Date: _____

Employee_____ Date_____

Supervisor_____ Date_____

APPENDIX C: FUNDING, SPONSORSHIP AND FACILITATION OF THIS EVENT

FUNDING

The Center for Substance Abuse Treatment

The Center for Substance Abuse Treatment (CSAT) of the Substance Abuse and Mental Health Services Administration (SAMHSA), within the U.S. Department of Health and Human Services (HHS), promotes the quality and availability of community-based substance abuse treatment services for individuals and families who need them. CSAT works with States and community-based groups to improve and expand existing substance abuse treatment services under the Substance Abuse Prevention and Treatment Block Grant Program. CSAT also supports SAMHSA's free treatment referral service to link people with the community-based substance abuse services they need.

CSAT was created in October, 1992 with a congressional mandate to expand the availability of effective treatment and recovery services for alcohol and drug problems. CSAT supports a variety of activities aimed at fulfilling its mission: To improve the lives of individuals and families affected by alcohol and drug abuse by ensuring access to clinically sound, cost-effective addiction treatment that reduces the health and social costs to our communities and the nation.

CSAT's initiatives and programs are based on research findings and the general consensus of experts in the addiction field that, for most individuals, treatment and recovery work best in a community-based, coordinated system of comprehensive services. Because no single treatment approach is effective for all persons, CSAT supports the nation's effort to provide multiple treatment modalities, evaluate treatment effectiveness, and use evaluation results to enhance treatment and recovery approaches.

SPONSORSHIP

Southeast Addiction Technology Transfer Center

Southeast Addiction Technology Transfer Center (ATTC) is one of 14 Regional Centers in the Addiction Technology Transfer Center Network. Funded by the Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment (SAMHSA, CSAT), Southeast ATTC:

- Fosters alliances and collaborative efforts to support and implement the most effective evidence-based practices in the treatment of substance use disorders
- Provides training, technical assistance, and other technology transfer activities to increase the awareness, knowledge, and skills of practitioners and pre-service professionals
- Develops and disseminates written resources to assist the treatment field and allied health and human service fields in their pursuit of greater effectiveness

Southeast ATTC is also a project of Morehouse School of Medicine (MSM) - National Center for Primary Care (NCPC). It has been in existence at MSM since 1993, serving practitioners in Georgia and South Carolina. Southeast ATTC fosters cultural appropriateness, cultivates system change, disseminates addiction information, identifies resources, and promotes evidence-based treatment approaches that will build an improved workforce and serve the community more effectively.

The Principal Investigator of Southeast ATTC is Kay Gresham, LCSW, ACSW.

The Addiction Technology Transfer Center Network

Building on a rich history, the Addiction Technology Transfer Center (ATTC) Network is dedicated to identifying and advancing opportunities for improving addiction treatment. The Network's vision is to unify science, education, and services to transform the lives of individuals and families affected by alcohol and other drug addiction.

The Network undertakes a broad range of initiatives that respond to emerging needs and issues in the treatment field. The Network is funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) to upgrade the skills of existing practitioners and other health professionals and to disseminate the latest science to the treatment community. The ATTC Network uses those resources to create a wide range of products and services that are timely and relevant to the many disciplines represented by the addiction treatment workforce.

Serving the 50 U.S. states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands and the Pacific Islands, the ATTC Network operates as 14 individual Regional Centers joined by a National Office.

Morehouse School of Medicine

Morehouse School of Medicine (MSM) is a historically black institution established to recruit and train minority and other students as physicians, biomedical scientists, and public health practitioners who are committed to the primary healthcare needs of the underserved. It was established as a two-year educational program in the basic sciences in April, 1975 as The School of Medicine at Morehouse College.

The School has a unique history. In 1973, Morehouse College received a federal grant to conduct a feasibility study on the development of a two-year program to train students to work as primary care physicians in medically underserved areas. The study revealed the severe shortage of African-American and other minority physicians in the United States, particularly in Georgia, and a general shortage of physicians in rural areas and the inner cities of the nation.

To address the critical health manpower needs of the citizens of Georgia and those who reside in medically underserved areas of the nation, the National Medical Association endorsed the development of a new medical school at Morehouse College. Other organizations, including the Georgia State Medical Association, the Georgia General Assembly, and the Carnegie Council, also supported the development of a new medical school at the College. Morehouse College accepted this challenge.

The charter class of twenty-four students entered a two-year basic science program in September, 1978. Those students, and the subsequent two classes, transferred from The School of Medicine at Morehouse College to other medical schools elsewhere in the country to complete their clinical training. The School of Medicine became independent of Morehouse College in 1981 and became a full four-year program in 1985.

The National Center for Primary Care

The National Center for Primary Care (NCPC) is a national resource for encouraging doctors to pursue primary care careers, for making primary care practice more effective, and for supporting primary care professionals working in underserved areas.

The NCPC team provides training for primary care practitioners, conducts practice-based research to improve health outcomes, creates protocols and tools for improving primary care effectiveness, and undertakes policy analyses focused on ways of making primary care more accessible and more effective.

The mission of the National Center for Primary Care is to promote excellence in community-oriented primary health care and optimal health outcomes for all Americans, with a special focus on underserved populations and on the elimination of health disparities.

The building that houses the National Center for Primary Care is a national resource for encouraging doctors to pursue primary care careers, for making primary care practice more effective, and for supporting primary care professionals serving in underserved areas. It is the administration headquarters for NCPC leaders, researchers, and programs, and the home of the Masters in Public Health Program, Preventive Medicine Residency Program, Faculty Development Program, and Center of Excellence for Research on Health Disparities.

FACILITATION

Terence T. Gorski

Terence T. Gorski is a pioneer in the development of Relapse Prevention Therapy, who has achieved international acclaim for his work. He is considered a leader and authority in the addiction, behavioral health, social services, and correctional industries for his work in recovery and relapse prevention.

Mr. Gorski holds a Bachelor of Arts Degree in Psychology and Sociology from Northeastern Illinois University and a Master of Arts Degree from Webster University in St. Louis, Missouri. He is also a Certified Addiction Professional in Florida, a Master Addiction Counselor (MAC) and Nationally Certified Addiction Counselor (NCAC II) by NAADAC, and a Senior Certified Addiction Counselor (CSAC) in the State of Illinois.

Mr. Gorski is the Founder and President of The CENAPS® Corporation and is currently a lecturing professor and Coordinator of the Addiction Studies Concentration at the Tampa Bay Campus of Springfield College. Mr. Gorski also serves on the Board of Directors of the Florida School of Addiction Studies and Florida NAADAC.

Mr. Gorski was awarded the Order of the Falcon On October 2, 2002. This is an international humanitarian award granted by the government of Iceland for his contributions to helping Iceland address its addiction problems. He also received The Father Martin Award in 2003 for his lifetime work in providing effective treatment to chronic relapsers. He was presented with The Clyde and Marie Gooderham Award from The University of Utah-School on Alcoholism and Other Drug Dependencies June 20, 1990, in recognition for his distinguished contributions to the field of addiction sciences. He was also a recipient of the Marty Mann Award for distinguished service to the field of addiction.

Mr. Gorski's practical approach to recovery and relapse prevention is based on more than thirty-five years' experience as a therapist, supervisor, program administrator, and consultant. He has become a leading authority on the use of science-based models for preventing relapse. His unique approach to treatment system development is biopsychosocial in nature and integrates the use of cognitive, affective, behavioral, family, and community recovery methods.

His greatest talent is his ability to break down complex treatment and recovery processes into clear and simple steps that can be used by professionals working with addicted people in addiction treatment programs, mental health centers, and the criminal justice system.

Mr. Gorski is a prolific author and has published such classics as *Staying Sober: A Guide for Relapse Prevention and Passages Through Recovery: An Action Plan for Preventing Relapse*. His most recent book addresses depression and relapse.

The Gorski-CENAPS Corporation

CENAPS® (an acronym for Center for Applied Sciences) is the private training and consultation firm founded by Terence T. Gorski in 1982. CENAPS® is committed to providing the most advanced clinical skills training for the addiction and behavioral health fields. Working with individuals and treatment providers, The CENAPS® Corporation makes Recovery and Relapse Prevention available to communities, to help chemically addicted relapse-prone clients.

Terence T. Gorski trains organizations on a comprehensive system for treating addiction and related personality disorders, mental disorders and situational life problems, with in-depth consultation and training services.

The mission of The CENAPS® Corporation is simple: All people will have access to affordable resources for developing effective recovery and relapse prevention plans.

The CENAPS® Vision includes helping people and their families recover from chemical dependency and other behavioral health problems by providing programs that focus on:

- Clinical skills training for treatment providers and their staff.
- Consultation for managed care and treatment organizations, including programs to assist organizations in setting goals, identifying and clarifying problems, and establishing strategic plans for improving program effectiveness.
- Education and training products, including audio- and video-assisted consultation packets and recovery guides.